CHAPTER 4
SECTION 1.1

MHS ENTERPRISE WIDE REFERRAL AND AUTHORIZATION SYSTEM (EWRAS)

1.0. GENERAL

1.1. The Government will operate and maintain an electronic MHS Enterprise Wide Referral and Authorization System (EWRAS) capable of accepting and sending referrals and authorizations. Through a component module the EWRAS will also generate and send Non-Availability Statements (NASs) to all Managed Care Support Contractors (MCSCs). The system will receive and route electronic referral and authorization transactions between the various MHS direct care and purchased care contractors, e.g., Military Treatment Facilities (MTFs) and MCSCs. For auditing and other administrative purposes, the system will capture and store the referral and authorization data. The system will be able to receive, process and send non-HIPAA-compliant ASC X12N 278 Health Care Services Review – Request for Review and Response transactions. NASs will be sent to the MCSCs using non-HIPAA compliant but standard 278 transactions (see paragraph 4.0. below for additional information regarding NASs). In addition to being Electronic Data Interchange (EDI) capable, the system will contain a web-application component that will be instantly accessible by the MHS community from the DoD enterprise wide web site, TRICARE Online (TOL). The system will route network referral requests from the MCSCs to the appropriate MTFs for first right of refusal, allowing care availability determinations by MTFs prior to referrals being made to the civilian network by the MCSCs. The system will also transmit NASs to the appropriate MCSCs for claims processing purposes. The MCSCs are required to maintain their own internal referral and authorization system and files on which the information exchanged with the EWRAS, including NASs, will reside and be accessible for claims processing and other administrative purposes.

2.0. REFERRALS

2.1. Referrals to the MCSCs may be requested from health care providers via letter, facsimile, or electronic means. If requested electronically, referrals will be sent via HIPAA-compliant ANSI ASC X12N 278 standard transactions. The contractor must be able to send and receive the HIPAA-compliant ANSI ASC X12N 278 transactions. If received by means other than electronic, the MCSC can access the EWRAS and manually enter the referral request into the EWRAS or enter the referral into their own system and securely send it through the EWRAS to the appropriate MTF via ANSI ASC X12N 278 standard transactions. All referrals generated or received by the contractors shall be loaded to their internal referral and authorization systems where they will be accessible to the claims processing and customer service systems.

2.2. The government requires first right of refusal for referrals for specialty care requested by network providers. All requests for specialty care referrals from network providers must be sent to the appropriate MTFs to determine care availability within the MTF before referrals are made to the civilian network.

Generally, responses to the referral request to the MTFs will be received by the MCSC within 24 hours. MCSCs may not assume a refusal until an actual reply from the MTF is received. MCSCs shall address acceptable referral response turnaround times in the Memorandum of Understandings (MOUs) with each MTF. The four week maximum wait time for a specialty care appointment begins from the time the beneficiary requests an appointment.

2.3. The MCSC shall update any changes to the status of referrals to include changes to civilian specialty care appointments and requests for additional information from network providers through the EWRAS. If the MCSC receives updated information from network providers electronically, the updates may be sent using HIPAA-compliant ANSI ASC X12N 278 standard transactions. If updates are received by means other than electronic, the MCSC may manually update the referral in EWRAS or enter the update into their internal referral and authorization system and securely send it through the EWRAS to the appropriate MTF via HIPAA-compliant ANSI ASC X12N 278 standard transactions.

2.4. The MCSC shall ensure that specialty consultation or referral reports, operative reports, and discharge summaries are provided to beneficiary referring/initiating providers within 10 working days of the specialty encounter 98% of the time. In urgent/emergent situations, preliminary reports of the specialty consultations shall be conveyed to the beneficiary referring / initiating providers within 24 hours (unless best medical practices dictate that less time is required for a preliminary report) by telephone, fax or other means with formal written reports provided within the standard 98% of the time. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the provider who initiated within 30 calendar days. The preferred method of delivery to MTF providers is electronic and shall be addressed in the Memorandum of Understanding (MOU) between the MCSC and each MTF. Should accreditation standards organizations or federal law or regulation (such as HIPAA) mandate more stringent referral reporting requirements, the contractor shall adhere to those standards.

MCSCs (and other MHS contractors using the EWRAS) shall work with TMA to develop and implement appropriate electronic transactions that can be used with the ANSI ASC X12N 278 standard transaction to convey specialty consultation, referral reports and discharge summaries within the EWRAS. Should accreditation standards organizations or federal law or regulation (such as HIPAA) or TMA mandate standard electronic transactions to convey reports, the contractor shall adopt those transactions upon contract modification.

3.0. AUTHORIZATIONS

3.1. Authorizations issued by the contractor may be sent via letter, facsimile, or electronic means. If sent electronically, authorizations shall be sent using HIPAA-compliant ANSI ASC X12N 278 standard transactions.

3.2. Authorizations issued by the MTF may be sent via letter, facsimile, or electronic means. If sent electronically, authorizations shall be sent using HIPAA-compliant ANSI ASC X12N 278 standard transactions. Contractors shall receive electronic authorizations from MTFs generated through the EWRAS via ANSI ASC X12N 278 standard transactions.

3.3. All authorizations generated or received by the contractors shall be loaded to their internal referral and authorization systems where they will be accessible to the claims processing and customer service systems.

4.0. NON-AVAILABILITY STATEMENTS (NASs)

4.1. Non-Availability Statements are issued to TRICARE non-enrolled beneficiaries and permit care outside of a MTF as stipulated by policy and the MTF Commanders. MCSCs shall receive NAS information via unsolicited ANSI ASC X12N 278 Health Care Service Review transactions from the EWRAS.

NOTE: While ANSI ASC X12N 278 Health Care Service Review transactions will be used by the EWRAS to transmit NAS data to the MCSCs, NASs are not considered a HIPAA-covered transaction. NASs are not referrals or authorizations as defined under HIPAA. As their name indicates, NASs are statements of non-availability. They communicate to beneficiaries and to TRICARE claims processors that required care is not available within an MTF. NASs make no referrals to specific providers nor do they request or grant authorization for specific procedures. They advise that an MTF cannot provide the needed care and that the patient is permitted to seek treatment outside of the MTF. The HIPAA Transaction and Code Set Final Rule defines a Referral Certification and Authorization as follows:

> "The Referral certification and authorization transaction is any of the following transmissions:
>
> (a) A request for the review of health care to obtain authorization for the health care.
>
> (b) A request to obtain authorization for referring an individual to another health care provider.
>
> (c) A response to a request described in paragraph (a) or paragraph (b) of this section."

NASs do not meet the above definition and are, therefore, not considered a HIPAA-required transaction.

4.2. NASs will be created by MTFs, translated into ANSI ASC X12N 278 Health Care Services Review transactions by the EWRAS, and routed to the MCSCs as unsolicited 278s. MCSCs shall load all NAS data received to their internal referral and authorization systems where they will be accessible to the claims processing and customer service systems.

5.0. EWRAS ACCESS THROUGH TRICARE ONLINE (TOL)

5.1. The EWRAS is located on the TOL platform and access to TOL will be required. MCSCs and other contractors that use the EWRAS will be given specific privileges within TOL which will allow them to perform all contract required functions within the EWRAS.

5.2. TOL Authentication

5.2.1. Each MCSC, or other contractor required to use the EWRAS, shall identify a primary and a backup "TOL Administrator." Contractors shall coordinate with the TOL Program Office to complete administrative requirements necessary to establish the TOL Administrator roles.

5.2.2. TOL Administrators will have the authority to authenticate contractor personnel who need access to functionality on TOL to perform their work and assign appropriate permissions to each user. TOL Administrators shall also activate and deactivate user TOL accounts.

5.2.3. Contractors shall ensure that all user names and passwords associated with TOL are secure and maintained in accordance with all government security requirements.

5.3. Should TOL or the EWRAS go down, contractors should contact the TOL Tier 2 Help Desk at: 1-800-501-8662. If there are planned system maintenance or downtime, the TOL Tier 2 Help Desk will notify the contractors of the consequent non-availability of the system. All contractors using TOL and the EWRAS shall identify and provide the Tier 2 Help Desk with the names, telephone numbers, and e-mail addresses of contractor points of contact (POC) who can be notified by the TOL Tier 2 Help Desk of system problems. Contractors shall provide the TOL Tier 2 Help Desk with POC updates on a quarterly basis or more frequently should contractor POCs change.

5.4. Contractor users of the EWRAS shall complete all required TOL and EWRAS web-based training courses as defined by the TOL Program Office.

5.5. Contractors who will exchange electronic transactions with the EWRAS shall provide the TOL Program Office with the electronic addresses to which the EWRAS should send the transactions in sufficient time (as defined through coordination discussions between the TOL Program Office, the contractors, and the Contracting Officers) to permit testing and production implementation. The TOL Program Office will also provide the EWRAS electronic addresses to the contractors. Any changes to electronic addresses must be coordinated in advance with the TOL Program Office.

6.0. CONTINGENCY PLAN FOR REFERRAL AND AUTHORIZATION

6.1. In the event that the Government's MHS Enterprise Wide Referral and Authorization System is not operational, and upon direction of the Contracting Officer, the contractor shall implement the following contingency plan for referrals and authorizations. Contracting Officers will issue a modification to the contract providing direction to implement the contingency plan and funding information.

6.2. The requirements of the contingency plan for referral and authorization apply to all TRICARE programs that require authorization prior to receipt of services, including but not limited to the Program for Persons with Disabilities (PFPWD) and its successor, the Extended Care Health Option (ECHO).

6.3. Referrals

The contractor and MTF shall establish referral mechanisms to ensure optimal utilization of MTF facilities and resources and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTFs. The contractor shall contact the MTFs to determine capacity before recommending or authorizing care with civilian providers. The referral-facilitation services of the contractor are primarily for ensuring access to care for enrolled beneficiaries; however, nonenrolled beneficiaries are encouraged to use the contractor's referral-facilitation services to find care in the network under TRICARE Extra. [(Nonenrollees are required to seek authorizations from the contractor prior to an NAS being issued] When space is not available in the MTFs, Medicare-eligible beneficiaries can use the contractors referral-facilitation services to access providers who accept Medicare assignment. The contractor and the MTF will work out a mutually acceptable process as to how the MTF will provide the contraxtor the MTF generated referral and authorization requests to civilian providers. The contractor shall perform the following principal functions:

6.4. Referral To Primary Care

Enrolled beneficiaries must initially obtain most health care services from their PCMs or have their claims adjudicated in accordance with the Point of Service provisions (*TRICARE Reimbursement* Manual, *Chapter 2, Section 4*).

6.5. Referral For Mental Health Services

Enrollees may seek outpatient mental health services through their PCMs. The contractor shall ensure that the network mental health provider obtains an authorization from the contractor for services rendered. This authorization is only to ensure that claims are processed appropriately and is not a prospective review. For nonenrolled beneficiaries who initially contact the contractor at the TRICARE Service Center or by telephone, the contractor shall maintain mechanisms to facilitate referrals to care. These mechanisms shall be made available to the Regional Director(s) or their designee(s). In catchment areas containing more than one MTF, the contractor shall, after consultation with the Regional Director(s) or their designee(s) and the MTF Commanders and in accordance with DoD policy, establish mechanisms to ensure that: all MTF resources in the area are considered before recommending or authorizing care with civilian providers (determinations on MTF referrals shall be subject to travel distances to the MTF where services are available for patients with consideration given to the nature of the medical problem); and coordination is maintained among the respective TRICARE Service Centers. All network mental health providers shall agree to provide TRICARE Prime beneficiaries' PCMs with a report of the treatment rendered if the beneficiary authorizes the release of the information and when referred by the PCM.

6.6. Referral To Specialty And Inpatient Services

6.6.1. In each catchment area, the MTF is the first choice provider for all nonemergency specialty and inpatient care for the TRICARE program unless otherwise indicated by the MTF Commander. The contractor is responsible for coordinating the referral function for both beneficiaries and network providers. If services are not available at the MTF, the beneficiary shall be referred to the contractor's network. If the required care is not available

in the network, the health care finder shall arrange for care through a non-network provider. The contractor shall ensure that all specialty and inpatient care for enrollees, whether provided in the MTF or in the civilian network, has been authorized.

6.6.2. The contractor shall establish referral procedures to ensure access to specialty and inpatient health care services for all MHS-eligible beneficiaries, especially enrollees. Contractors shall apply Prime copayments, not Point of Service cost-sharing provisions, when PCMs, network providers and/or contractor staff do not follow established referral/authorization procedures. For example, if the contractor processes a claim without evidence of an authorization and/or a referral under Point of Service provisions, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim under Prime provisions. The contractor need not identify past claims, however the contractor shall adjust these claims as they are brought to their attention.

6.6.3. The contractor shall assist the PCM in facilitating specialty and inpatient referrals for care available in the MTF or, if not available (or not available within a medically appropriate time period), to a provider within the contractor's network except in those cases where, for a Prime enrollee with an MTF PCM, the MTF has determined, after consultation with the contractor, that the care required could be provided more cost-effectively by a non-network provider.

6.6.4. If services are not available, or not available within the medically appropriate time period from a provider in the contractor's network, the contractor shall arrange for care with a provider outside the contractor's provider network. Contractors shall apply Prime provisions to claims for referred and authorized care received by Prime enrollees from non-network providers. Contractors shall ensure that referring network providers and contractor staff follow established referral/authorization procedures in order to avoid the inappropriate application of Point of Service cost-sharing to claims for referred/authorized care received by Prime enrollees from non-network providers.

6.6.5. The contractor shall ensure that TRICARE Prime enrollees receive care from network providers and shall authorize the use and services of each non-network provider involved in referred care including institutions that use consultants or other non-network providers. MTFs may refer their Prime enrollees to a non-network provider who is determined to be less costly or in instances where there are no clinically appropriate network providers. The contractor shall facilitate the referral. Referrals shall be processed on CHCS (when required by contract).

Note: Effective with care received on or after March 16, 1998, on claims for Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers, enrollees shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to *TRICARE Reimbursement* Manual, *Chapter 3, Section 1* for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to *TRICARE Reimbursement* Manual, *Chapter 2, Section 1* for information on claims for certain ancillary services. Contractors need not review past claims for those

processed under obsolete requirements. If, however, it is brought to a contractor's attention that a claim was processed according to previous requirements and the date of service is on or after March 16, 1998, the contractor shall adjust the claim according to the new requirements.

7.0. AUTHORIZATIONS

7.1. For Prime enrollees, all specialty and inpatient medical care not provided by the PCM except emergencies, outpatient mental health services referenced in paragraph 6.4. above, clinical preventive services supplied by network providers, and services obtained under the Point of Service option must be referred from the PCM and authorized by the contractor or other contractor designee. This requirement is applicable for services referred to the MTF when the enrollee has been assigned a PCM in the network or for services referred to a provider outside the MTF when the enrollee has been assigned an MTF PCM.

7.2. Nonenrolled beneficiaries are not required to obtain authorization for care from the contractor except when an NAS is required. Providers serving nonenrollees shall comply with the prior authorization requirements established under TRICARE Operations Manual, Chapter 7, Section 2.

7.3. For beneficiaries who are not enrolled to an MTF, the contractor shall ensure that care provided, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5. The contractor shall use best practices in reviewing and approving care and establishing medical management programs to carry out this activity to the extent authorized by law. Notwithstanding the contractor's authority to utilize its best practices in managing, reviewing and authorizing health care services, the contractor shall comply with the provision of 32 CFR 199.4 and the TRICARE Policy Manual regarding review and approval of mental health services.